NEW PATIENT SCHEDULING

Please complete all fields and click submit at the bottom. Once we receive the completed form, we will contact you to schedule your appointment.

[NEW PATIENT ENROLLMENT] Referred by: *

- [ ] NONE
- [ ] Provider Office
- [ ] Hospital
- [ ] CVS/HealthHub
- [ ] CPR
- [ ] CUSD (for outpatient services)
- [ ] Other

Referring facility, clinician, organization, or individual name & contact info: *

Simple Text

Patient Full Name *

First name | Last name

Date of Birth (MM-DD-YYYY) *

Simple Text

Email Address *

Your email

Phone Number *

Phone number

Current Home Address

Street Address | Address Line 2

State/Province/Region | Postal/Zip Code

City

PLEASE CONFIRM (by checking box). LIGHTHOUSE PSYCHIATRY BRAIN HEALTH CENTER providers: (1) DO NOT provide any forensic psychiatry/therapy mandated by court order, state professional licensing boards, or any evaluations will be used as material items for future court or board hearings; (2) not all providers accept Medicare; and (3) not contracted with medicaid (AHCCCS). *

- [ ] Yes. I acknowledge, understand and accept statement.

PLEASE CONFIRM (by checking box). LIGHTHOUSE WELLHEALTH/WELLHEALTH CLINIC (nonprofit) providers: (1) DO NOT provide any forensic services; (2) not all providers accept Medicare; and (3) not contracted with medicaid (AHCCCS) [contracting in progress]. *

- [ ] Yes. I acknowledge, understand and accept statement.

PLEASE CONFIRM (by checking box). I am financially responsible for all fees, including insurance deductibles/copays/co-insurance, insurance non-covered services, drug screening, no show/late cancellation, and any accrued balance from services rendered. Beware: my credit/debit card information will be securely stored on fine. I authorize Lighthouse to charge my card to pay for my outstanding fees. *

- [ ] Yes. I acknowledge, understand, and accept statement.

PLEASE select PAYMENT option(s) [select all that applies] *

- [ ] SELF-PAY (no AHCCCS)
- [ ] SELF-PAY (AHCCCS is secondary)
- [ ] COMMERCIAL insurance
- [ ] COMMERCIAL (EAP) insurance
- [ ] MEDICARE
- [ ] MEDICAID (AHCCCS, Mercy Care)
- [ ] MILITARY insurance (TriCare-West, TriWest (CCN)).
- [ ] HB2502
- [ ] Laloboy Foundation
- [ ] Other

PRIMARY Insurance (Commercial) *

Simple Text

PRIMARY Insurance Claims Address

Street Address

Address Line 2

City

State/Region/Province

Postal/Zip Code

PRIMARY Insurance Claims Phone *

Phone

Subscriber Name *

First Name

Last Name

Subscriber Date of Birth (MM-DD-YYYY) *

Simple Text

Subscriber Relationship *

Select Item

Member ID *

Simple Text

Group Number

Simple Text

SECONDARY Insurance (Please list ALL) (If None, write "None" in section.)

Simple Text

Patient is a MINOR (<18 years old)? (BEWARE: If parents are DIVORCED or GUARDIAN, please upload any legal custody documents below) *

- [ ] NO, I am an adult.
- [ ] YES, minor has MARRIED parents.
- [ ] YES, minor has DIVORCED parents with JOINT CUSTODY. (upload court documents)
- [ ] YES, minor has DIVORCED parent with SOLE CUSTODY. (upload court documents)
- [ ] YES, minor has GUARDIAN parents.

Patient has ACTIVE or PENDING legal case? (BEWARE: Our providers do not appear in court. But if need be and coordination with court is required, and a service fee will be charged to patient.) *

- [ ] NONE. I have no active/pending legal case.
- [ ] YES. Workman Comp (explain below)
- [ ] YES. Custody Court (explain below)
- [ ] YES. Personal Injury (explain below)
- [ ] Other (explain below)

Type of Provider(s) Needed [select all that applies] *

- [ ] ADVANCED INTERVENTIONAL TREATMENTS [TMS, MeRT, Spravato, Ketamine, Photobiomodulation, IV Nutrition]
- [ ] PSYCHIATRY [medication management]
- [ ] COUNSELING [talk therapy]

****COUPLES/MARRIAGE/FAMILY THERAPY: Who will accept responsibility as the "chart holder" of records?**

Simple Text

****COUPLES/MARRIAGE/FAMILY THERAPY: Who will accept financial responsibility?**

Simple Text

Reason(s) for Appointment (select ALL that applies) *

- [ ] Medication Treatment
- [ ] TMS/MeRT for Depression, Anxiety, PTSD, TBI
- [ ] TMS/MeRT for Autism (ASD)
- [ ] TMS for OCD
- [ ] Spravato (esketamine) for Depression
- [ ] Spravato (esketamine) for Suicidal Ideation
- [ ] Ketamine Infusion (IV)
- [ ] Nutrition Infusion (IV)
- [ ] ADHD diagnosis & treatment
- [ ] Individual talk therapy
- [ ] Marriage/Couples talk therapy
- [ ] Family talk therapy
- [ ] PTSD/Trauma talk therapy - EMDR
- [ ] PTSD/Trauma talk therapy - ART
- [ ] Treatment Solutions for Veterans
- [ ] Autism (ASD)
- [ ] Concussion/TBI
- [ ] Depression
- [ ] Anxiety
- [ ] Grief
- [ ] Postpartum depression
- [ ] Psychosis
- [ ] Personality Disorder (ie. Borderline)
- [ ] Behavioral/School Issues
- [ ] Foster/Adoption Support
- [ ] Recent Suicidal Ideation
- [ ] OTHER (comment below)

Patient is in ACTIVE treatment for SUBSTANCE ABUSE? (select ONE) *

- [ ] YES, currently in INPATIENT detox treatment program
- [ ] YES, currently in OUTPATIENT substance treatment program (MAT, substance IOP, treatment with Methadone or Suboxone or Subutex)
- [ ] NO, discharged from detox program LESS THAN 30 days
- [ ] NO, discharged from detox program MORE THAN 6 months
- [ ] NO, NEVER undergone, referred for, or refused detox treatment for substance abuse

Patient is ACTIVELY using the following substance(s) WITHOUT a prescription. (select ALL that applies) *

- [ ] NONE
- [ ] Alcohol (daily use)
- [ ] Marijuana
- [ ] Ecstasy, MDMA
- [ ] Methadone, Amphetamine
- [ ] Cocaine, Heroin, Crack, LSD, Hallucinagens
- [ ] Opioids (Fentanyl, Morphine, Oxycodone (Percocet), Dilaudid, etc)
- [ ] Benzodiazepine (Xanax, Valium, Ativan, Klonipin, Tamazepam) (please list amount in comment below)
- [ ] OTHER (comment below)

Patient interested in ADVANCED treatment(s). *

- [ ] TMS (Transcranial Magnetic Stimulation)
- [ ] Advanced EEG-Guided TMS (MeRT)
- [ ] Spravato (esketamine)
- [ ] Ketamine IV Infusion
- [ ] Photobiomodulation (Titan IR)
- [ ] None

<> Patient has been DIAGNOSED with? *

- [ ] Severe Depression (MDD)
- [ ] Severe Depression (MDD) with Anxiety
- [ ] Severe Depression (MDD) with Recent Suicidal Thoughts
- [ ] Generalized Anxiety Disorder (GAD)
- [ ] Bipolar I/II Disorder (BP)
- [ ] Obsessive Compulsive Disorder (OCD)
- [ ] Posttraumatic Stress Disorder (PTSD)
- [ ] Concussion/TBI/Brain Injury
- [ ] Postpartum Depression (PPD)
- [ ] Autism (ASD)
- [ ] Other
- [ ] None of the above

<> Patient has tried ANTIDEPRESSANT medications? *

- [ ] 0 antidepressant medication
- [ ] 1-2 antidepressant medications
- [ ] 3-4+ antidepressant medications

<> Patient has tried following ADVANCED treatment(s)? *

- [ ] YES. TMS helped my symptoms.
- [ ] YES. ECT helped my symptoms.
- [ ] YES. Spravato helped my symptoms.
- [ ] YES. IV Ketamine helped my symptoms.
- [ ] NO, but I want to learn more about these treatments.
- [ ] NO, I am not interested.

<> Any presence of non-removable metal in head? *

- [ ] NONE
- [ ] Metal fragments
- [ ] Aneurysm clips
- [ ] Skull plates
- [ ] Cochlear implant
- [ ] Deep brain stimulator implant
- [ ] Vagal nerve stimulator implant

[Required] Additional Information (Please provide brief description of your needs, situation or any information to clarify questions above) *

Paragraph

Upload the following: (1) insurance card (FRONT & BACK), (2) photo ID (FRONT & BACK), (3) court custody documents, and (4) any other supporting materials (30MB file size limit)

Drop your files here 

Submit Now